# Lesotho - Health Sector

Report generated on: July 3, 2018

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# Overview

## Identification

**COUNTRY**
Lesotho

**EVALUATION TITLE**
Health Sector

**EVALUATION TYPE**
Independent Performance Evaluation

**ID NUMBER**
DDI-MCC-LSO-HEALTH-PDG-2018-v1

## Version

**VERSION DESCRIPTION**
- v01: Edited, anonymous dataset for public distribution.

## Overview

**ABSTRACT**
This performance evaluation is designed to address a range of evaluation questions and sub-questions about the program logic and current status of the health system, including:

1 Was the program evaluable?

2 Was the program implemented according to plan?

3 What was achieved with respect to patient outcomes?

4 What proportion of community members use the HCs and OPDs? Why do those who choose not to seek treatment, not seek care?

5 What was achieved with respect to health professional outcomes?

6 Did the NHTC investment contribute to increased enrollment and graduation from NHTC?

7 What was achieved with respect to system outcomes?

8 What lessons can MCC or the Government of Lesotho apply in future programs related to program design, implementation, and sustaining results? What could have been done better? How so?

The time frame of the exposure to the Activities or outputs of the Health Project differs for the various Activities. The first Activities of the Health Project were completed in 2010 (reconstruction of the Domiciliary Health Center in Maseru) and the last Activities in 2014 (reconstruction of Health Centers), four years before data collection. Although some outcomes might be expected right away, like increased enrollment at NHTC, others might take more time to materialize like the effect on quality of care of in-service training of staff, as a result of the policies and guidelines developed by the Health Project. It is expected that all outcomes of interest will have materialized by the time of data collection. This expectation is in line with the ERR assumption that the net annual benefits would start to accrue 10 years after the start of the Compact, i.e., from 2018 onwards, which implies that some benefits started to accrue several years earlier. Hence, data collection in 2018 can be considered appropriate timing. However, one caveat is that recollection of earlier experiences will likely be difficult or impossible to capture due to elapsed time.

**EVALUATION METHODOLOGY**
Pre-Post

**UNITS OF ANALYSIS**
Patients, health professionals, health care system, districts, OPDs, HCs

**KIND OF DATA**
Sample survey data [ssd]

**TOPICS**

| Topic | Vocabulary | URI |
|---|---|---|
| Health | MCC Sector | |
| Hospitals | | |

**KEYWORDS**
Health, Hospitals, Lesotho

## Coverage

**GEOGRAPHIC COVERAGE**
The Health Project had national coverage in terms of the health care facilities improved and communities benefiting

## Producers and Sponsors

**PRIMARY INVESTIGATOR(S)**

| Name | Affiliation |
|---|---|
| Pim de Graaf | |

**FUNDING**

| Name | Abbreviation | Role |
|---|---|---|
| Millennium Challenge Corporation | MCC | |

## Metadata Production

**METADATA PRODUCED BY**

| Name | Abbreviation | Affiliation | Role |
|---|---|---|---|
| Millennium Challenge Corporation | MCC | | Review of Metadata |

**DATE OF METADATA PRODUCTION**
2018-07-02

**DDI DOCUMENT ID**
DDI-MCC-LSO-HEALTH-PDG-2018-v1

## MCC Compact and Program

**COMPACT OR THRESHOLD**
Lesotho Compact I

**PROGRAM**
According to the 2004 Lesotho DHS, 24 percent of adults age 15-49 in Lesotho were infected with Human Immunodeficiency Virus (HIV) prior to the Lesotho Compact. The Compact, which was implemented from 2008-2013, invested approximately $140 million in a Health Project in order to strengthen the country's health care system and thereby mitigate negative economic impacts of HIV/Acquired Immune Deficiency Syndrome (AIDS), poor maternal health, tuberculosis (TB) and other diseases. In particular, infrastructure funded under the Lesotho Compact was expected to provide a sustainable platform for the delivery of anti-retroviral therapy and other essential health services throughout the country; such services were expected to result in a measurable extension of productive life-years for people living with HIV/AIDS, TB and other debilitating diseases. The Health Project included the following seven Activities and accompanying sub-Activities, which were

complemented by investments from other donors in the sector: 1 Renovation and equipment of 138 Health Centers (HCs) throughout the country 2 Renovation and equipment of 14 Out Patient Departments (OPDs) attached at hospitals (out of 16), to ensure HIV/AIDS care 3 Reconstruction and equipment of a Central Laboratory, including staff training 4 Construction and equipment of a Central Blood Transfusion Facility and of two regional centers, including provision of vehicles for mobile units and staff training 5 National Health Training College, which consisted of additional dormitories for students, staff housing, equipment, and software 6 Health Systems Strengthening, which included: · Strengthening of pre- and in-service training capacity · Support to the process of decentralization of service delivery · Support to the Research and Development Unit within the Ministry of Health · Support to development of health information systems (note: this investment is not referenced in the Lesotho Compact) 7 Support to update and implement the Government's Medical Waste Management Plan

**MCC SECTOR**
Health (Health)

**PROGRAM LOGIC**
The Health Project consisted of several Activities that intended to jointly strengthen the country's health system. Through improved infrastructure, equipment, and training, the Project sought to improve perceptions of the health system, the quantity and quality of staff, expand the services offered, tests conducted, quantity and quality of blood collected and available for use, and increase use of the health care system. Intermediate and long-term outcomes are better service delivery that reaches more people, and decreased morbidity and mortality, especially with respect to maternal health care, and treatment of patients with HIV/AIDS and TB. These outcomes were expected to result in more productivity and ultimately a reduction of poverty.

**PROGRAM PARTICIPANTS**
The Health Project was designed to improve health outcomes for people using the HCs and OPDs renovated under the Lesotho Compact. In addition, patients in all hospitals in the country are potential “participants” since blood transfusions are given in all of the hospitals, with more frequent use in Maseru hospitals. The Project also provided a considerable amount of training and was intended to support increased enrollment at NHTC, so health professionals and students can also be considered “participants.”

# Sampling

## Sampling Procedure

Central level
No sampling was carried out for data collection at central level, because all relevant partner-organizations were included in the data collection.
Peripheral level
At peripheral level, in order to limit the amount of data and effort while preserving sufficient numbers to allow for observation of trends and variations, the following sampling steps were taken to achieve a broad representation of perspectives on the basis of population numbers, variations in geographical conditions and available resources for this evaluation.
Districts
Six out of the 10 districts in Lesotho were selected for data collection. This number was presumed to cover sufficient population and health facilities to be representative. The sampling was stratified: first, in view of its population size, Maseru district in the lowlands was included. Then, the other five districts were randomly selected from the remaining nine. In order to cover sufficient geographic diversity, at least one of the mountain districts needed to be included. This was motivated by the known climate, access and isolation issues in those districts. If this did not happen through random sampling, one of the lowlands/foothills districts would have been dropped (randomly selected) and replaced by one of the four mountain districts, again randomly selected.
All OPDs reconstructed in the six districts were included. In each OPD, there were two target groups of professionals: The manager and two doctors. Prior to and during the visits of the evaluation team, in agreement with the manager of the OPD/hospital, the survey-respondents were selected on the basis of availability and convenience. Length of tenure was an additional selection criterion, if choice existed.
In order to limit the number of Health Centers to visit while also ensuring sufficient representation, a sample of three Health Centers were randomly selected in each district. In Maseru district an additional two Health Centers were randomly selected because of the population size, which accommodates around 25% of the total population of the country. Further, a minimum of six isolated Health Centers spread over the five districts were to be included, in order to ensure their sufficient representation in the study. If the above random sampling resulted in less than six, additional isolated Health Centers would have been selected randomly, with a maximum of one per district. If the two Health Centers supported by the Red Cross were not included in the above sampling, they would have been added. In term of health care staff, two nurses were to be invited to participate in the survey: the head nurse and the newest nurse. When the head nurse was not available, another nurse was selected on the basis of availability and longest serving years.
Six patients were also targeted at each OPD and HC (two adult women, two adult men, two care givers). Consecutive patients exiting the health facility were asked to participate, which continued until the sample size had been reached for each of the 3 categories to be sampled. If there were insufficient patients from one or more of the 3 categories, no substitution occurred. However, the timing of the survey was determined to ensure sufficient availability of patients. Concretely this meant that the survey was carried out between mid-morning and the end of the morning, when consultations are typically ongoing.

## Response Rate

Quantitative

The above-mentioned sampling and selection procedure resulted in 26 health centers and 10 OPDs in six districts (of 10 total districts in Lesotho) for the HFS sample. The HFS was implemented in all these facilities, see the table below.

With the exception of male patients, the response rates for the sub-groups targeted are at or above 100 %, as the table shows. In some health facilities, there were simply no (or insufficient numbers of) male patients, which was compensated by including more female patients or care takers.

Observation modules of HFS were also completed in all 36 facilities.

HFS Response Rates
Target population Patient females Patient males Patient - care takers Staff Manager
Target number 72 72 72 72 36
Surveys conducted 86 69 77 108 36
Response Rate 119% 96% 106% 150% 100%

Qualitative
In all 26 selected health centers, the planned FGD VHWs took place. The discussion was conducted in Sesotho and later transcribed and translated in English.

The planned semi-structured interviews with members of the District Health Management Team (DHMT) took place in the targeted six districts. However, in practice became FGDs with a varying number of DHMT members (mostly 4-6 members). Also, the interviews with doctors in each of the 10 OPDs were conducted.

At central and national level, most of the planned key informant interviews were carried out. Where respondents were unavailable, the evaluator attempted to collect information by email.

# Questionnaires

## Overview

A Health Facility Survey (HFS) conducted in 2018 built on an earlier HFS conducted in 2011. This survey collected data from health care workers (managers and health professionals) about the physical and psychological working environment and tools, career issues, how they perceive the patient experience, the use of the EMRS and HCWM, and views of characteristics and quality of the services delivered in their current health service. HFS also interviewed patients/users of OPDs and Health Centers to collect data on their perception of the health services and the care provided, obstacles to care, physical environment, staff attitude, quality of care and general atmosphere in the country with regards to stigmatization of certain population characteristics like HIV. Finally, the survey included a module that collected observation data. HFS was conducted in Sesotho. All surveyors were proficient in Sesotho and English and had relevant professional qualifications.
Qualitative data were also collected in the form of key informant interviews, focus group discussions (FGDs) with Village Health Workers (VHWs), and observations of health facilities.

Kinds of data produced:
Qualitative: Key Informant Interviews, Focus Group Discussions, Observations
Quantitative: Health Facility Survey (with patient and health professional modules), administrative data

# Data Collection

## Data Collection Dates

| Start | End | Cycle |
|---|---|---|
| 2018-02-01 | 2018-04-30 | N/A |

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## Data Collectors

| Name | Abbreviation | Affiliation |
|---|---|---|
| Pim de Graaf | | |
| Basotho Staff | | |
| | | |

# Data Processing

No content available

# Data Appraisal

No content available